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Last, First, MI, Suffix (Jr., III):_____ **Rank:** _____
SSN (FMP/xxx-xx-xxxx): _____**Age/DOB (annotate both):**_____ **Sex:** _____

Service: ☐**USAF** ☐**USA** ☐**USN/USMC** ☐**USCG** ☐**OTHER** _____ **Status:** ☐**Active Duty** ☐**Guard** ☐**Reserve**

Occupation/AFSC/MOS (annotate both):_____ **Flying Status:** YES ☐ NO ☐ **ASC:** _____

Date of Separation/Retirement: _____ **A date is absolutely required.**

CURRENTLY ANTICIPATE OR UNDERGOING MEB: _____

Contact Info:

Address: _____ Unit: _____

Phone (H): _____ Base: _____

Phone (C):_____ Phone (W):_____

MILITARY EMAIL*:_____

Commander's email (for profile processing) _____

Medical Information: (please annotate completely. If nothing to annotate, please write "nothing")

Drug Allergies/Sensitivities: _____

Current Medications: _____

Medical History: _____

Surgical History: _____

Do you now or have you ever had any of the following eye conditions?

	YES	NO		YES	NO		YES	NO
Glaucoma	☐	☐	Keratoconus	☐	☐	Ocular allergies	☐	☐
Dry eyes	☐	☐	Cataract	☐	☐	Strabismus/lazy eye	☐	☐
Eye surgery	☐	☐	Eye injury	☐	☐	Corneal infection/scars	☐	☐
Retinal problems	☐	☐	Ocular Rosacea	☐	☐	Ocular Herpes infection	☐	☐

Do you have any of these medical conditions?

	YES	NO		YES	NO		YES	NO
Diabetes	☐	☐	Psoriasis	☐	☐	Immunosuppression	☐	☐
Migraines	☐	☐	Pacemaker	☐	☐	Tuberculosis or positive PPD	☐	☐
Acne rosacea	☐	☐	Thyroid Disease	☐	☐			

Do you have an autoimmune disease or have you been evaluated by a specialist for possible autoimmune disease? YES ☐ NO ☐

Examples: Rheumatoid arthritis, Lupus, Multiple Sclerosis, Sarcoid, Sjogren's, Irritable Bowel Disease, HLA B27, psoriasis, vitilligo

Have you ever taken any of the following? YES ☐ NO ☐ If yes, mark box and indicate LAST DATE used in blanks.

☐Steroids _____ ☐Small pox vaccine _____ ☐Accutane (Isotretinoin)_____
☐TB meds (INH)_____ ☐Immitex (sumatriptan) _____ ☐Cordarone (Amiodarone)_____

Have you ever worn contact lenses? YES ☐ NO ☐ If yes, which type: ☐Soft ☐Hard ☐Unsure
How many years? _____ How many hours per day? _____ What date did you last wear? _____

****Soft contact lenses *must not be worn* 30 days prior to the preop exam or surgical date. Rigid Gas Permeable contacts *must not be worn* 90 days prior to the preop exam/surgical date. Initial here that you have read and understand this statement _____****

Females Only: Are you currently pregnant or planning to become pregnant in the next 6 months? YES ☐ NO ☐
Are you nursing or have you been nursing/pregnant in the last 6 months? ☐ ☐

List your hobbies or activities having special visual requirements (Ex: flying, swimming, golf, shooting, sewing)

_____

Describe your expectations from refractive surgery: (Ex: to see the clock in the morning, while swimming)

_____

I, _____, AFFIRM THAT THE INFORMATION CONTAINED HEREIN IS TRUE, CORRECT, AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. Signature: _____ Date: _____

(This form is subject to the Privacy Act of 1974 – DD Form 2005)

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Preferred language: ☐ English ☐ Other: _____

What is your preferred method of learning? ☐ Written ☐ Visual ☐ Other:

(if other specify): _____

Do you have a learning disablity, language barrier/hearing/vision deficit? ☐ No ☐ Yes

(if yes specify): _____

Do you have an advance directive completed? ☐ Yes ☐ No

Is a copy of the advance directive in your record? ☐ Yes ☐ No

Do you have any cultural or religious beliefs that may affect your care? ☐ No ☐ Yes

(if yes specify): _____

I understand that by committing to the refractive surgery program I will adhere to the post-op mandatory 1, 2, 3, 6 & 12 month follow-up visits, even if I PCS after treatment is provided. These are WRESCu directed and not a choice. Failure to comply with follow up appointments or persistent no-shows will result in notification to my leadership.

Signature _____